Public Health Agency of Canada

2007-08

Departmental Performance Report

Leona Aglukkaq
Minister of Health

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MINISTER'S MESSAGE

I am pleased to present the 2007-08 Performance Report for the Public Health Agency of Canada. The Agency continues to play a vital role in contributing to the Government of Canada's ability to promote and protect the health of Canadians.

The Agency is the third largest federal organization with programs and initiatives contributing to the health of Canadians. It enhances the Government of Canada's ability to improve and maintain the health of Canadian families by delivering new and ongoing public health information programs. These included activities such as the healthy pregnancy initiative, partnering on the World Health Organization's groundbreaking Age-Friendly Cities Guide, and updating Canada's Physical Activity Guides with versions for children, youth, adults and seniors.

The Agency also works to enhance Canada's emergency preparedness, which includes planning for pandemic influenza. While we cannot always predict the timing of emergencies and pandemics, we can be as prepared as possible. Through the Agency's work, and supported by its surveillance systems, nationwide quarantine service and effective emergency response protocols, we are in a better position than ever to protect Canadians and respond to outbreaks of infectious disease and foodborne illness, as well as other emergencies that impact human health.

As demonstrated in this Performance Report, the Agency has been key to this Government's ability to take concrete action on public health issues and to deliver on its commitments to achieve healthier Canadians and a stronger public health capacity. We continue to build on the expertise of our officials as well as our many partners and stakeholders, because health protection and promotion are most successful when all sectors of society are involved.

In support of a stronger public health system in Canada and around the world, I am proud to report on the significant achievements made by the Agency during its third full year of operation.

The Honourable Leona Aglukkaq
Minister of Health
Government of Canada

CHIEF PUBLIC HEALTH OFFICER'S MESSAGE

Created in 2004, the Public Health Agency of Canada has, in a relatively short period, made real progress in strengthening public health in Canada. This is in large part due to how we have brought a collection of programs, activities and expectations together into an effective and unified federal entity charged with protecting and promoting the well-being of Canadians.

There is today a recognition across Canada of the very clear need for the Agency to exist as the federal partner in a system designed to improve and protect the public's health. While emergency preparedness and response is a key responsibility, the Agency addresses the totality of the population's health. We protect against and respond to outbreaks and emergencies, but we also strive to prevent the basic things that kill and disable Canadians every day.

In 2007-08, we continued to work with our partners and stakeholders on health promotion and the prevention and control of chronic diseases. This included launching a second national healthy pregnancy advertising campaign, and work on healthy aging that led to international recognition of Canada's Minister of Health's leadership role in seniors' health issues.

Of course, one of our highest priorities as an Agency continues to be to prepare for public health emergencies, including a potential influenza pandemic. This Performance Report reviews key steps taken during the 2007-08 fiscal year on emergency preparedness and response, including building surge capacity and negotiating how different governments and stakeholders will work together to detect and respond to public health emergencies.

Most public health activities involve broad collaboration across a range of actors. This creates challenges for performance measurement, as positive health outcomes and trends usually reflect the success of joint efforts by multiple partners. For instance, in many of its activities the Agency works closely with the other members of the Health Portfolio as well as many other federal departments and agencies whose work has an impact on public health. Our collaboration with provinces, territories and other countries in how we face current and future threats to public health is key to our success.

Now, almost four years since it was established, the Agency finds itself turning a corner. We have in place programs, activities, communications strategies, and agreements that together prepare us for the range of threats to the health of the population. We work not in isolation, but in concert with our many partners, in a public health system that is one of the best in the world. With all of this in place, we have a tremendous opportunity to move forward and make real and lasting change to the well-being of our communities and population.

I am pleased to take part in this accounting to Parliament and to all Canadians, and am proud of our dedicated staff across the country who continue to make progress in fulfilling our vision of healthy Canadians and communities in a healthier world.

Dr. David Butler-Jones, M.D.
Chief Public Health Officer

Overview

Section I

Summary Information

Reason for Existence

Public health involves the organized efforts of society to keep people healthy and to prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians. In Canada, public health is a responsibility that is shared by the three levels of government, the private sector, non-government organizations, health professionals and the public. In 2003, the emergence of the Severe Acute Respiratory Syndrome (SARS) demonstrated the need for a national focal point for public health issues. In response to this need, the Public Health Agency of Canada (Agency) was created on September 24, 2004 within the Health Portfolio to deliver on the Government of Canada's commitment to help protect the health and safety of all Canadians. Its activities focus on preventing chronic diseases, like cancer and heart disease, preventing injuries and responding to public health emergencies and infectious disease outbreaks.

Roles and Responsibilities

The Agency has the responsibility to:

- lead the prevention of disease and injury, and the promotion of health;
- provide a clear focal point for federal leadership and accountability in managing public health emergencies;
- serve as a central point for sharing Canada's expertise with the rest of the world and applying international research and development to Canada's public health programs; and
- strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning.

In December 2006, the *Public Health Agency of Canada Act* came into force, giving the Agency the statutory basis to continue fulfilling these roles. The Agency delivers on its mandate by:

- anticipating, preparing for, responding to and recovering from threats to public health;
- surveillance, monitoring, researching, investigating and reporting on diseases, injuries, other preventable health risks and their determinants, and on the general state of public health in Canada and internationally;
- using the best available evidence and tools to advise and support public health stakeholders, nationally and internationally, as they work to enhance the health of their communities;
- providing public health information, advice and leadership to Canadians and stakeholders; and
- building and sustaining a public health network with stakeholders.

Operations across Canada

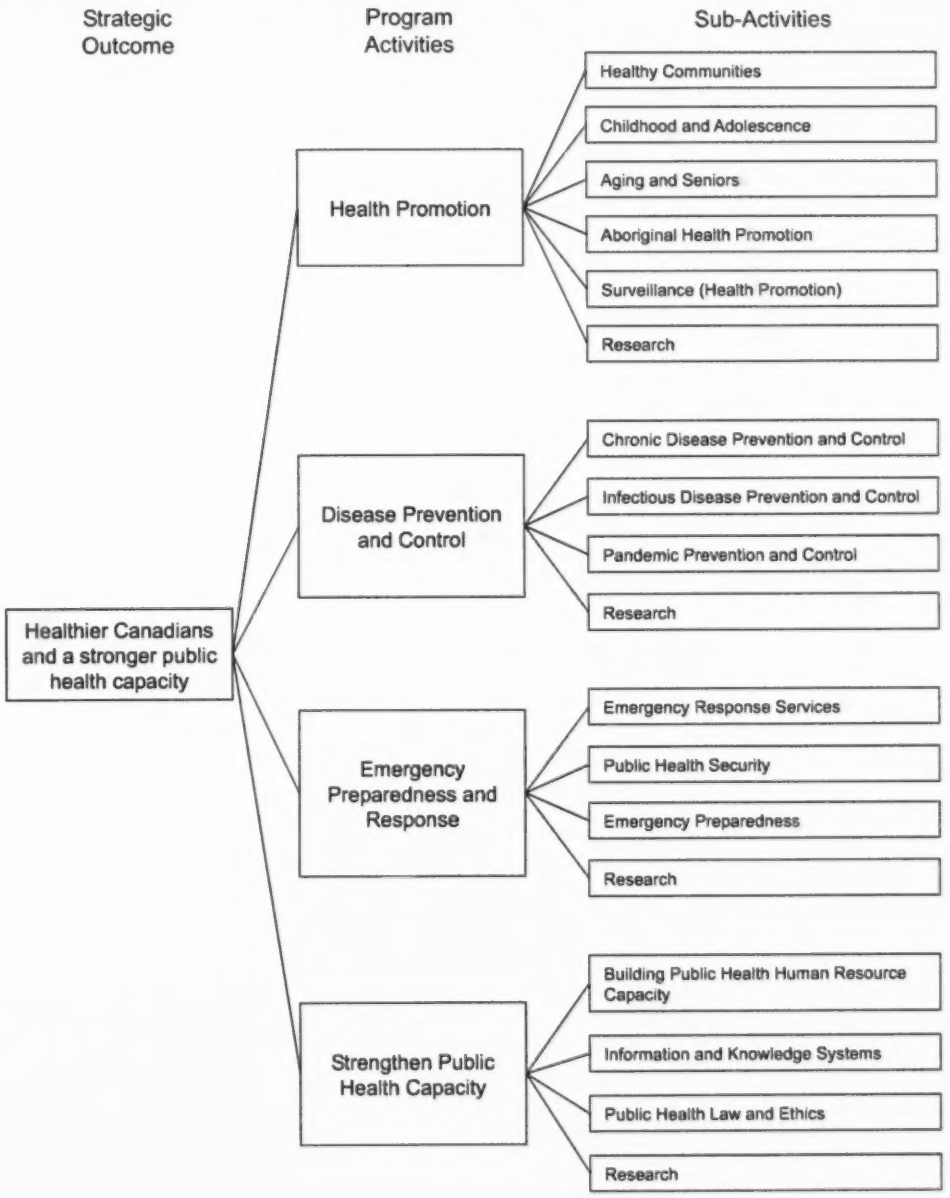
To carry out these roles and responsibilities, the Agency has developed a strong presence throughout the country, so that it can connect with provincial and territorial governments, federal departments, academia, voluntary organizations and citizens.

The Agency is supported by two pillars of expertise in Winnipeg, Manitoba and Ottawa, Ontario. The rest of the Agency's Canada-wide infrastructure consists of 16 locations in six Regions. Under an interdepartmental agreement, some programs are also delivered to the Yukon, Nunavut and the Northwest Territories through Health Canada's Northern Region office. In addition, the Agency operates specialized research laboratories across Canada. These laboratories play a key role in identification, control and prevention of infectious diseases.

Overall Agency Performance

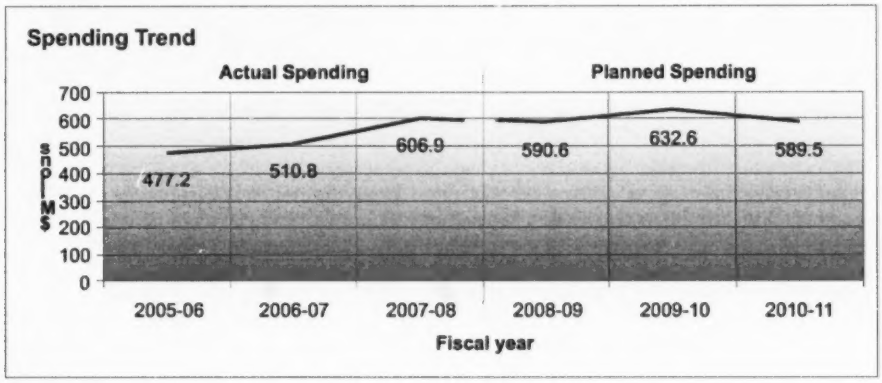
Program Activity Architecture

The chart below illustrates the Agency's framework of program activities and program sub-activities which contributed directly to progress toward a single Agency Strategic Outcome: Healthier Canadians and a stronger public health capacity. Collectively, they contributed to the Government of Canada outcome of healthy Canadians and indirectly to other outcomes such as safe and secure communities; a fair and secure marketplace; and a safe and secure world through international cooperation.



Expenditure Profile

The Agency's actual spending for 2007-08 was $606.9 million. Over the past three years, spending increased by $130 million (or 27%) mainly due to funding announced in Budget 2006 for Preparedness for Avian and Pandemic Influenza and in Budget 2005 for the Integrated Strategy on Healthy Living and Chronic Disease. Growth was partly offset by incremental Expenditure Review Committee reductions flowing from Budget 2004 and 2005.



2007-08 Actual Spending Comparison

The increase in planned spending in 2009-10 is mainly due to funding approved for the hepatitis C Health Care Services Program. The decrease in planned spending in 2010-11 is mainly due to one-time funding that was previously provided for certain Avian and Pandemic Influenza Preparedness activities. In addition, spending associated with the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program has been reduced in fiscal year 2010-11, to account for the sunsetting of the Program (the program's terms and conditions are set to expire in 2010-11).

Financial Resources ($ millions)

Planned Spending	Total Authorities	Actual Spending
669.8	684.1*	606.9**

*The $14.3 million difference between planned spending and authorities is due to: (a) increase of $1.3 million for items in Supplementary Estimates (A) not included in Planned Spending; (b)decrease of $1.5 million for transfers to other departments in Supplementary Estimates (B); (c) increase of $20.3 million for transfers from Treasury Board votes for the operating budget carry-forward from 2006-07 ($14.8 million), and to cover other operational requirements such as Collective agreements ($1.5 million), uncontrollable salary costs ($4.0 million); and (d) decrease of $5.8 million due to reduction in Employee Benefit Plan costs.

** Actual spending was $77.2 million lower than total authorities due to the deferment of funding to subsequent fiscal years ($35.6 million in operating expenditures and $4.6 million in transfer payments); capacity and technical restraints which impeded the full utilization of approved resources ($28.4 million in operating expenditures); and delays in the approval and solicitation process in addition to transitions to the new Innovation Learning Strategy and to the Canadian Strategy for Cancer Control ($8.6 million in transfer payments).

Human Resources (Full-Time Equivalents*)

Planned	Actual	Difference
2376	2165	211**

* Full-Time Equivalents are calculated based on days worked, in order to properly include persons employed for part of the year and/or employed part time in a measure showing average employment over the year.

** The difference of 211 Full-Time Equivalents is due to: (a) delays in the staffing process; (b) difficulty in finding qualified personnel because of low labour market availability for positions requiring unique public health specialization; and (c) constraints due to shortage of accommodation space.

Agency Priorities

#	Priority	Type	Performance Status	Explanation of Performance
1	Develop, enhance and implement integrated and disease-specific strategies and programs for the prevention and control of infectious disease	Ongoing	Successfully Met	The Agency collaborated both domestically and internationally on immunization and vaccine-preventable diseases; took a leadership role in the Federal Initiative to Address HIV/AIDS in Canada; and provided surveillance for infectious diseases.
2	Develop, enhance and implement integrated and disease- or condition-specific strategies and programs within the health portfolio to promote health and prevent and control chronic disease and injury	Ongoing	Successfully Met	The Agency worked with multiple domestic and international partners and stakeholders to mobilize efforts across various levels and sectors to promote the health of Canadians. As well, the Agency prevented and controlled chronic disease and injury by identifying and responding to key risk factors.
3	Increase Canada's preparedness for and ability to respond to public health emergencies, including pandemic influenza	Ongoing	Successfully Met	The Agency engaged in emergency preparedness and response planning with federal/provincial/territorial departments and agencies, and non-governmental organizations to identify emerging priorities, establish work plans and coordinate activities.
4	Strengthen public health within Canada and internationally by facilitating public health collaboration and enhancing public health capacity	Ongoing	Successfully Met	The Agency provided resources and tools to facilitate public health work done by all levels of government and institutions across Canada in order to develop a seamless, comprehensive and sustainable public health system. Through partnerships and joint initiatives, the Agency led and supported public health professionals and stakeholders in their efforts to keep pace with rapidly evolving conditions, knowledge and practices.
5	Lead several government-wide efforts to advance action on the determinants of health	Ongoing	Successfully Met	The Agency has brought together Canadian government and non-government stakeholders to share promising approaches such as those outlined in a global study on intersectoral action. The Agency has also collaborated with several departments to advance action on the determinants of health, such as health literacy in Canada.
6	Develop and enhance the Agency's internal capacity to meet its mandate	Previously committed	Partially met	The Agency initiated strategic and business planning processes that addressed capacity issues, including expansion of laboratories and further development of the Winnipeg headquarters and regional offices. However, neither a Performance Measurement Framework nor an Evaluation Plan were finalized in 2007-08. As well, more work needs to be done on developing risk management strategies within the Corporate Risk Profile. The Management Accountability Framework assessment by the Treasury Board Secretariat has identified four areas where improvement is necessary (i.e., managing organizational change; effectiveness of information management; effective project management; and effective management of security and business continuity). Together, these issues provide a critical path for the Agency's improvement agenda over the next year.

Program Activities by Strategic Outcome

Strategic Outcome: Healthier Canadians and a Stronger Public Health Capacity

Program Activity	Expected Results	Performance Status	2007-08 Planned Spending ($millions)	2007-08 Actual Spending ($ millions)	Contributes to Priority #	Alignment to Government of Canada Outcomes
Health Promotion	• Improved health and well-being • Improved health behaviours • Reduced health disparities	Successfully met	186.5	192.1	2, 4 and 5	Healthy Canadians
Disease Prevention and Control	• Decreased proportion of Canadians who develop or acquire disease • Maintained and enhanced quality of life; fewer complications and premature deaths in those with disease • Decreased personal, social and economic burden of disease for individuals and society • Strengthened response to managing diseases in Canada	Partially met	311.8	240.5	1, 2 and 4	Healthy Canadians
Emergency Preparedness and Response	• Canada is one of the countries best prepared to respond to the public health risk posed by natural and human-caused disasters, such as infectious disease outbreaks, hurricanes, floods, earthquakes, and criminal or terrorist acts such as explosions and the release of toxins	Successfully met	115.9	121.3	3	Healthy Canadians
Strengthen Public Health Capacity	• Strengthened public health capacity in Canada through enhancements to the public health workforce, public health information and knowledge systems, and public health law and ethics	Successfully met	55.6	53.0	4	Healthy Canadians

Strategic Context, Operating Environment and Risk Analysis

In recent years, the Government of Canada has identified several priorities in the Speech from the Throne and the Federal Budget ranging from health threats to children and seniors, to enhancing laboratory safety. Responding to these priorities has presented both challenges and opportunities to the Agency.

PHAC facts...

As highlighted in the 2007 Speech from the Throne, there is a strong link between health and the environment. Growing populations are placing an increased pressure on the global environment while, in Canada, greater urbanization brings increased concentrations of toxins and pollutants, as well as increased demands for energy, land and other resources. Changes in Canadian society have also resulted in shifts in behavioural patterns (e.g., unhealthy eating and physical inactivity) and in living and working conditions. All of these changes could lead to a higher risk of chronic disease incidence and additional costs on the health care system and the economy.

Globalization

Societies and economies are becoming increasingly interdependent. The increased volume and speed of trade and travel has brought significant economic benefits and challenges to Canadians. Keeping pace with the demands of a global economy has meant greater time pressures for families. With less time, families consume more convenience foods and are less physically active which translates into risks such as obesity. Higher mobility of people also raises the risk of infectious disease outbreak.

Population

Canada has the highest rate of population growth among the eight economically-leading countries. Given Canada's dependence on immigration to support economic growth, there is a need to focus attention on immigrants' health issues who are more likely than those born in Canada to rate their health as fair or poor health. The health of immigrants (measured by diagnosed chronic disease) becomes progressively worse with increasing length of residence in Canada. Innovative approaches to understanding, assessing and addressing non-medical determinants of health are also being developed in collaboration with domestic and international partners. These approaches will inform more effective interventions to reduce health disparities borne by Canada's vulnerable populations including First Nations, Inuit and Metis people, children, seniors, and people living in rural and remote areas.

Diseases

Although chronic disease is the leading cause of death in Canada, the impact of an uncontrolled outbreak of an infectious disease would be immense. As seen with SARS, even the perception that an infectious disease is out of control can cause major social and economic disruptions. Climate change and the growing global population increase the risk of a new disease – and an outbreak anywhere in the world can swiftly appear in Canada. The challenges associated with such infectious diseases as avian influenza and "superbugs" often mean that national and international approaches are required to address disease transmission and control.

PHAC facts...

- *Obesity is a significant risk factor for a range of health issues.* About 65% of men and 53% of women did not have healthy weights in 2004. An estimated 26% of children and youth between the ages of 2 and 17 were either overweight or obese. *As the population ages and if obesity rates continue to rise, increased rates of diabetes, cancer and cardiovascular disease can be expected. In addition to the health impact, the economic costs of unhealthy eating and physical inactivity are significant. However, a study published in 2000 by the Canadian Medical Association estimated that a ten percent increase in the proportion of Canadians who are physically active could save $150 million annually in health care costs for coronary heart disease, stroke, type 2 diabetes, colon cancer, breast cancer and osteoporosis.*

Sexually-transmitted infections, blood-borne infections (e.g., hepatitis) and Tuberculosis collectively represent over 50 percent of all reportable infections/diseases in Canada. It is also estimated that 250 000 Canadians develop healthcare- associated infections and 8000 die as a result each year. The cost of healthcare associated infections to the Canadian healthcare system is estimated to be between $453 million and $1 billion annually while the costs associated with hepatitis C virus alone is projected to cost Canada $1 billion annually by 2010. With increasing incidence of antimicrobial resistant forms of these diseases, the healthcare, economic and personal burdens will continue to grow.

Science and Technology

The rate of scientific discovery and technological innovation has increased dramatically in the past decade. By providing new approaches for improving health and preventing disease, these innovations can mitigate pressures on the health system. Advances in public health genomics – an emerging field that assesses the impact of the interaction between genes and the environment on population health – creates research that can be applied to prevent disease and improve the health of Canadians.

Partnerships and Stakeholders

The Agency depends greatly on partners and stakeholders to achieve long-term expected results for Canadians. For example, actions the Agency has taken to support disease prevention and control are primarily in surveillance and knowledge transfer in keeping with our federal role. The Agency engages stakeholders through national-level bodies to develop and achieve consensus on standards; develop surveillance systems; identify best practices; and so on. As well, the Agency's community-based chronic disease prevention activities are only funded in the area of diabetes. An external diabetes policy review has advised that even these activities should focus more on knowledge development and on pilot projects that will test promising practices. In addition, emergency preparedness activities rely on collaboration across national and international jurisdictions in order to ensure timely and effective risk management.

Analysis of Program Activities by Strategic Outcome

Section II

In 2007-08, the Agency had four program activities — health promotion, disease prevention and control, emergency preparedness and response, and strengthen public health capacity. Some of the work done in these program activities included using information generated from surveys and other research studies to monitor, plan, implement and evaluate programs. The Agency also used a mix of policy development and program delivery activities to carry out its responsibilities. In addition, the Agency's grants and contributions programs funded partners in the health sector and at the community level to pursue shared goals.

PHAC facts...

By most standards, Canadians' health ranks extremely well. 89% of Canadians report their health as either excellent (22%), very good (38%) or good (29%). However, people living in poverty, Aboriginal peoples and rural Canadians, experience considerably poorer health on average. This is particularly true when comparing Canada's infant mortality rate (which is among the lowest in the world at 5 deaths per 1000 live births) to the rate among First Nations people living on reserve (7 deaths per 1000 live births). And while life expectancy at birth in Canada averaged 80.4 years, life expectancy was 75.5 years for Aboriginal women and 70.4 years for Aboriginal men, almost 7 years less, on average, than for non-Aboriginal people.

Collectively, the Agency's four program activities contributed towards the strategic outcome of healthier Canadians and a stronger public health capacity.

Program Activity – Health Promotion

Financial Resources ($ millions)

Planned Spending	Total Authorities	Actual Spending
186.5	200.2*	192.1**

* The $13.7 million net increase between planned spending and authorities is due to: (a) increase of $7.9 million for operating budget carry-forward from 2006-07 ($6.9 million) and to cover other operational requirements such as collective agreements ($0.3 million) and uncontrollable salary costs ($0.7 million); (b) increase of $4.1 million resulting from realignment of resources between program activities to cover additional requirements in transfer payments; (c) increase of $3.6 million for items in Supplementary Estimates (A) not included in Planned Spending, such as one-time named grant for MedicAlert ($2 million) and 2008 Advertising campaign ($2 million); and (d) decrease of $1.9 million due to reduction in Employee Benefit Plan costs.

** Actual Spending was $8.1 million lower than Authorities due to: (a) capacity and technical restraints which impeded the full use of approved resources ($5.6 million in operating expenditures); and (b) delays in the approval and solicitation process and transition to the new Innovation Learning Strategy ($2.5 million in transfer payments).

Human Resources (Full-Time Equivalents)

Planned	Actual	Difference
416	381	35*

*The difference of 35 Full-Time Equivalents is due to: (a) delays in the staffing process; (b) difficulty in finding qualified personnel because of low labour market availability for positions requiring unique public health specialization; and (c) constraints due to shortage of accommodation space.

Health promotion is the process of enabling people to increase control over and improve their health. This process is based on the understanding of the important influences that determinants of health (such as gender, income, and literacy) have on an individual's health. Health promotion activities move beyond health education and changes in personal behaviours to address social change, institutional change and community change.

Performance Analysis

In 2007-08, the Agency re-issued *Canada's Physical Activity Guides* and made them available in versions for children, youth, adults and seniors. Over 1.2 million copies of these guides were distributed. The Agency also offered a *Sensible Guide to a Healthy Pregnancy* to provide the reliable information about how prospective mothers can safeguard their health and the health of the expected baby.

In 2007-08, funding was provided to support the creation of knowledge, skills, tools and resources to help communities, organizations and individuals act to improve their health. For example, Active Healthy Kids Canada developed a project called *Canada's Physical Activity Report Card for Children and Youth*. It provides a comprehensive measurement of how Canada is delivering on its responsibility to provide physical activity opportunities for children and youth, and also increases awareness and common understanding of the issue of physical inactivity. In addition, the annual SummerActive and WinterActive programs were implemented but were not sufficiently effective in reaching their target audiences. These initiatives were led by the Agency in collaboration with other government departments, and provincial and territorial governments. They were designed to help Canadians improve their health by encouraging them to adopt healthier lifestyles, including participating in physical and sport activities, making healthier food choices and living tobacco-free.

PHAC facts...

Children in Quebec are coping with their schoolwork crunch by enjoying a healthy daily crunch of fruits and vegetables. "My Daily Crunch" is an annual project supported by the Agency and administered by the Association régionale du sport étudiant de Québec et de Chaudière-Appalaches, a non-profit organization. Its collaborators include Capitale nationale and Chaudière-Appalaches regional public health directorates, IGA and the Quebec Produce Marketing Association. The project has developed support materials in English and French such as activity binders, information and promotional items. "My Daily Crunch" reaches over 800 elementary schools and some 220,000 children and their parents.

The Agency continued to support the four Centres for Excellence for Children's Well-Being (Early Child Development, Special Needs, Youth Engagement and Child Welfare) in translating knowledge into practical tools for parents using, an online Early Childhood Development Encyclopaedia. The Agency also provided a Special Needs Information Directory of services and resources available to parents of children with special needs. The usefulness of this work has been validated directly through a visitor survey.

The Agency funded community-based programs to increase access to health and social supports for prenatal and post-partum women and children facing challenges such as poverty, teen pregnancy, isolation, recent arrival in Canada and substance abuse. The programs were developed and delivered in partnership with the provinces and territories through joint management agreements. For example, the Community Action Program for Children (CAPC) funded community-based projects and coalitions serving more than 65 000 children and parents/caregivers in a month, in over 3000 communities. As well, the Canada Prenatal Nutrition Program (CPNP) funded community-based projects and coalitions in approximately 2000 communities, providing over 50 000 pre- and postnatal women with food supplements, as well as support, education and counselling on health and lifestyle issues.

PHAC facts...

A 2002 CAPC National Impact Evaluation demonstrated positive results of the child-caregiver funding. A 2007 formative evaluation demonstrated that CAPC mobilized communities in support of at-risk children and families.

A 2007 CPNP formative evaluation demonstrated that it has been successful in reaching its target population and achieving positive health results.

The Agency continued to fund the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program in collaboration with the provinces, territories and community organizations to provide culturally appropriate programs and activities for pre-school First Nations, Métis and Inuit children and their caregivers or parents. The program provided opportunities for preschoolers to learn readiness skills and acquire healthy living habits. At the same time, their parents and caregivers learned about healthy child development, practical child safety tips and what resources and services were available to them. During 2007-08, over 4,500 children were enrolled in 129 sites.

PHAC facts...

A 2006 National Impact Evaluation of the AHSUNC Program found significant gains for the target children in physical, personal, social and health development domains, as well as increased school readiness.

As a member of the Joint Consortium for School Health (a federal/provincial/territorial health and education consortium), the Agency contributed to the promotion of a comprehensive and coordinated

approach to school health across Canada through knowledge development, leadership and capacity building.

The Agency also supported the operations of the Canadian Health Network in its final year of operation. During 2007-08, the Network delivered quality, non-commercial health promotion information to over 4 million visitors to its website. Work was undertaken to enhance the Agency's own website to provide key health promotion information so that the continuing needs of the users would be met.

Other steps taken by the Agency focussed on enabling better collaboration, increased understanding and improved policies. For example, the Agency negotiated agreements on Physical Activity and Healthy Eating with eight jurisdictions (Alberta, British Columbia, New Brunswick, Northwest Territories, Nova Scotia, Nunavut, Ontario and the Yukon) to identify areas of common understanding for priority action and resources.

In 2007-08, the Agency supported the release of a report titled *Healthy Settings for Young People in Canada*, as part of the Health Behaviour in School-aged Children study conducted by Queen's University. As well, the Agency worked collaboratively with the World Health Organization (WHO) to develop a policy framework for the prevention of chronic diseases in schools.
With funding from the Agency, the Canadian Fitness and Lifestyle Research Institute carried out physical activity surveillance for children, youth and adults. This research helps all governments and stakeholders to shape policies and strategies that encourage and support regular physical activity. Also, a scientific review of physical activity guidelines and measurement was completed and published in a special joint issue of the Canadian Journal of Public Health and the Journal of Applied Physiology, Nutrition and Metabolism in November 2007.

PHAC facts...

A 2008 FASD summative evaluation found that 38% of respondents viewed the initiative as a key contributor to the change in the level of maturity within the communities over the past five years.

The Agency continued its surveillance of injuries in Canada, helping to identify trends, issues and priorities. For example, it supported and led the modernization of the Canadian Hospitals Injury Reporting and Prevention Program, and maintained up-to-date information for an on-line injury surveillance website, contributing to the evidence base for injury prevention.

The Agency led the Fetal Alcohol Spectrum Disorder (FASD) Initiative, which fosters a better understanding in Canada of the impact of alcohol use during pregnancy. The initiative aims to prevent alcohol-affected births and mitigate the impact of those already living with the condition. Funded projects resulted in advances in counselling women of child-bearing age and screening pregnant women for alcohol use. The Agency sponsored a National Roundtable on the Development of a Canadian Model for Calculating the Economic Impact of FASD which contributed to improving the tracking of both the economic and social costs of FASD, and to strengthening intervention planning, implementation and evaluation.

PHAC facts...

The CIS underwent a 2003 process evaluation which identified areas for improvement in efficiency and effectiveness in training material and data collection which have since been implemented. The CIS will be evaluated in 2008-10 after its third cycle.

In 2007-08, the Agency worked with all provinces and territories on the surveillance of both intentional and unintentional injury through tools such as the Canadian Hospitals Injury Reporting and Prevention Program and the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS). The CIS has been expanded to strengthen the data collection for child maltreatment for First Nations, Inuit and Métis children.

PHAC facts...

Recognizing that the achievement of results is cumulative and long-term, a recent release of the WHO Global Report on Falls Prevention in Older Age reinforces Canadian direction and practices of increasing awareness. This report is consistent with an earlier evaluation that found in general that initiatives and the responsible organizations provided relevant and value-added information.

Along with Health Canada, the Agency co-led an Interdepartmental Task Force to coordinate a potential federal strategy to address mental health and mental illness in Canada. The Agency also participated in the creation of a Mental Health Issue Group, a sub-group of the federal, provincial and territorial Public Health Network Population Health Promotion Expert Group.

The Agency continued to lead on healthy aging issues for seniors through its work on emergency preparedness and seniors; age-friendly communities; seniors' falls prevention and seniors' mental health. The Agency also contributed to knowledge development and transfer by providing useful resources on seniors' falls prevention, age-related chronic diseases, health promotion/public health issues in printed format (over 150 000 printed resources) and electronic dissemination (over 270,000 unique visitors).

During 2007-08, the Agency engaged domestic and international partners to develop and document the most effective means of addressing the factors that determine health and health inequalities, based on documented research findings. The Agency was successful in influencing the international agenda of the WHO to include issues particularly relevant to Canada (e.g., addressing the determinants of Indigenous Peoples' health). Additionally, the Agency facilitated communication, knowledge translation and multi-jurisdictional collaboration through the establishment of the Canadian Reference Group for the WHO Commission on Social Determinants of Health, a civil society network and links to the business sector to help advance work on health disparities.

PHAC facts...

Federal Health Minister Tony Clement received an international award from Help the Aged UK, distinguishing him as a leader on seniors' health issues. Dr. Jane Barratt, Secretary General of the International Federation on Ageing, acknowledged the leadership that the Agency has shown in a World Health Organization project developing an Age-Friendly Cities Guide. With 33 participating cities across the globe (including four Canadian cities), the project analyzed the needs of an aging population and created the guide to help communities make their urban centers more age-friendly. This ground-breaking initiative provides the tools necessary for cities to make their communities better, healthier and safer places for seniors – and persons of all ages - to live and thrive

Exceptions

All Health Promotion Program Activity work planned in the Report on Plans and Priorities (RPP) for the fiscal year 2007-08 was successfully achieved with the exception of:

- The Canadian Hospitals Injury Reporting and Prevention Program completed its modernization but did not release an annual report until 2008-09. This program is carried out in partnership with fourteen hospitals across the country, and operates with information systems, training, and services provided by the Agency.

Benefits to Canadians

The Agency made progress toward its expected results of improved health behaviours; improved health and well-being; and reduced health disparities through knowledge development and translation; collaborative policy development; public awareness efforts; and the development, assessment and monitoring of information and related systems. For more information on this program activity, please visit: (http://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.php).

Program Activity – Disease Prevention and Control

Financial Resources ($ millions)

Planned Spending	Total Authorities	Actual Spending
311.8	290.3*	240.5**

* The $21.5 million net decrease between planned spending and authorities is due to: (a) decrease of $16.9 million resulting from realignment of resources to cover increased requirements in other program activities; (b) decrease of $3.5 million due to reduction in Employee Benefit Plan costs; (c) decrease of $2.5 million for items in Supplementary Estimates (A) not included in Planned Spending; (d) decrease of $1.5 million for transfers to other departments in Supplementary Estimates (B), including to Health Canada for the Science Library Network A Base ($0.3 million), to Canadian Institute for Health Research for avian and pandemic research ($0.6 million), to Canadian Institute for Health Research for hepatitis C research training programs ($0.3 million) and to Department of National Defence for Chemical, Biological, Radiological-Nuclear and Explosives (CBRNE) Research and Technology Initiative (CRTI) acquisition plan ($0.3 million); and (e) increase of $2.9 million for transfers from Treasury Board votes to cover collective agreements ($0.8 million) and uncontrollable salary costs ($2.1 million).

** Actual Spending was $49.8 million lower than Authorities due to the deferment of $27.7 million in funding to subsequent fiscal years for Clean Air Agenda ($1.0 million), Canadian HIV Vaccine Initiative ($4.6 million), clinical trials related to Avian and Pandemic influenza ($15.6 million), and the Avian and Pandemic Winnipeg Laboratory and Space Optimization project ($6.5 million). *(Note that this laboratory is also known as the Logan, Ward or J.C. Wilt Laboratory.)* $16.5 million was lapsed in operating expenditures due to delays in staffing and other capacity and technical restraints which impeded the full utilization of approved resources and $5.6 million was lapsed in transfer payments due to delays in the approval and solicitation process and transition to the Canadian Strategy for Cancer Control.

Human Resources (Full-Time Equivalents)

Planned	Actual	Difference
1282	1168	114*

*The difference of 114 Full-Time Equivalents is due to: (a) delays in the staffing process; (b) difficulty in finding qualified personnel because of low labour market availability for positions requiring unique public health specialization; and (c) constraints due to shortage of accommodation space.

The Agency develops and implements policies and programs to prevent, control and reduce the impact of disease and injury. Disease prevention covers measures not only to prevent the occurrence of disease (e.g., risk factor reduction), but also to stop its progress and reduce its consequences once established. Disease prevention actions usually emanate from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours. Disease control means ongoing operations or programs aimed at reducing incidence and/or prevalence, or elimination of such conditions.

Performance Analysis

1. Decreasing the Proportion of Canadians who Develop or Acquire Disease

Work to decrease the number of Canadians developing or acquiring diseases included public health surveillance; immunization and pandemic preparedness; prevention and control measures; and provision of unique research and testing capabilities:

Public Health Surveillance

Public health surveillance is the ongoing, systematic use of routinely collected health data to guide timely public health action. Surveillance without effective follow-up does not limit disease, but it is critical to Canada's ability

PHAC facts...

In the May 2008 Report of the Auditor General of Canada, the Agency's surveillance of infectious diseases was examined and assessed. The Report concluded that "the Agency has the capacity and systems to detect an emerging infectious disease, a new strain of an existing disease, or a re-emerging infectious disease. We also conclude that the informal mechanisms for detecting and monitoring these diseases need to be strengthened. Coupled with gaps and delays in the supply of the data by the provinces and territories, this means that the Agency cannot always systematically analyze and report information on public health threats. The Agency is working to improve how it communicates relevant information to its partners." The Agency has also made several commitments to address other recommendations.

to anticipate, prevent, identify, respond to, monitor, and control diseases and injuries – and to the federal government's ability to design, deliver and evaluate public health activities. For this reason, surveillance is a core function of the Agency.

To obtain the needed information on what is impacting the health of the Canadian population, the Agency worked with federal departments and agencies and other levels of government, as well as health professionals, hospitals and laboratories across the country to deliver and improve approximately 20 public health surveillance programs.

Understanding and tracking chronic diseases, their risk factors and determinants with effective surveillance is a key element of chronic disease prevention and control. To address significant risk factors (e.g., obesity) or to understand the impact of changing demographics, chronic disease surveillance systems provide baseline information and track trends. To support planning, decision-making and measurement of progress, as well as to inform policies, programs, and services on chronic diseases, the Agency continued to provide timely, ongoing and comprehensive health information through its website, reports, conferences, and consultations with governments and stakeholders. The expansion of existing data sources (i.e., national data sources, Statistics Canada surveys, the Canadian Cancer Registry, hospitalization and mortality databases) was achieved with the addition of data from provincial and territorial health care system databases. Existing public analytic tools were also expanded to generate maps, graphs and tables of chronic diseases and their risk factors by region across Canada. Collaboration in 2007-08 with provinces and territories to develop a National Chronic Disease Surveillance System led to the approval of a Chronic Disease Surveillance Action Plan in April 2008.

The Agency continued to operate laboratories with strong analytical and research capabilities to help determine whether infectious disease cases are linked, whether there were new disease agents and how to combat transmission. Agency disease prevention and control resources also worked with partners across Canada to identify diseases and conditions to be monitored and reported, to establish what information is important to track and to help create agreements for information to be shared. The Agency received, stored, quality tested and analyzed the data; and published information products including the Canada Communicable Disease Report, Respiratory Virus Detections/Isolations in Canada and the Transfusion Transmitted Injuries Surveillance System Report.

The Agency continued to operate and enhance the Canadian Network for Public Health Intelligence, used by all provinces and territories, providing a method for distribution of information about relevant public health events. An Agency-developed system called the Global Public Health Intelligence Network (that continuously scans media reports from around the world in eight languages, with human analysts to filter and interpret the output) – continued to be relied upon by governments and international bodies as an essential information source about the spread of new infectious diseases.

PHAC facts...

In the May 2008 Report of the Auditor General of Canada, the development of the Global Public Health Intelligence Network (GPHIN) was cited as a major accomplishment for Canada. According to the report, Canada, other countries, and WHO depend on this system as an essential source of information about the spread of new infectious diseases. "An analysis by WHO found that during 2001 and 2002, the Network supplied about 40 percent of WHO's early warning outbreak information." GPHIN information accounts for over 50 percent of first-time reports of international public health events provided to the WHO.

The Agency undertook the implementation of the cell/tissue/organ transplantation and assisted human reproductive surveillance system, intensified/ enhanced surveillance of hepatitis B and C and needle stick injuries, and led a federal government initiative to monitor bird flu (avian influenza) in wild birds and potential human cases.

Immunization

Carried out by Canada's provinces and territories, immunization has proven to be one of the most cost-effective public health interventions. To help fulfill the federal role, the Agency collaborated internationally on issues related to immunization and vaccine-preventable infectious diseases, and also provided

scientific, program, policy, information dissemination, coordination and administrative support to the National Advisory Committee on Immunization, and the federal, provincial and territorial Canadian Immunization Committee (CIC). With Agency support, the CIC developed scientific and programmatic recommendations on Human Papillomavirus (which is associated with cervical cancer) to inform provinces and territories of options for immunization program planning.

As part of its leadership role in preparing for a potential avian or pandemic influenza, the Agency continued to administer contracts to develop and maintain domestic pandemic vaccine production and testing capacity.

To support the Canadian HIV Vaccines Plan and to contribute to the global response, the Agency participated in the Canadian HIV Vaccine Initiative. Partners in this Initiative include Health Canada, the Canadian Institutes of Health Research, the Canadian International Development Agency, Industry Canada, and the Bill and Melinda Gates Foundation. In addition, the Agency supported activities to increase manufacturing capacity for HIV vaccine clinical trial lots; strengthen policy approaches for HIV vaccines, promote the community and social aspects of HIV vaccine research and delivery; and enhance horizontal collaboration with domestic and international stakeholders.

PHAC facts...

The seven-year evaluation (1999-2000 to 2005-06) of the hepatitis C component of the Communicable Disease and Infection Control program recognized the significant strides made to address the hepatitis C epidemic. The program had an impressive record of achievement including: extensive capacity building; increased research capacity; significant efforts toward prevention; and establishment of key partnerships / collaborations. As a result, the Government approved funds to the Agency for "A Renewed Public Health Response to Address hepatitis C" to sustain and build on the accomplishments achieved to date.

Prevention and Control of Infectious Diseases

The Agency provided a national focus on communicable diseases and for foodborne, waterborne, and animal-carried infections. The Agency continued to maintain and publish guidelines for the prevention, diagnosis, treatment and management of disease such as hepatitis C, HIV/AIDS, Sexually Transmitted Infections and Tuberculosis. Its *Infection Control Guideline* series is widely used by health care providers, governments and other institutions as a source of best practice information used for the prevention and control of infections in health care facilities. These guidelines have now been adapted for the entire spectrum of Canadian health care providers, such as acute and long-term care, office and outpatient care, and home care.

The Agency continued to lead the Federal Initiative to Address HIV/AIDS in Canada, a partnership that includes Health Canada, the Canadian Institutes of Health Research and Correctional Service Canada. The Agency provided $20 million to community-based organizations to carry out 163 national and front-line activities across Canada. These activities – aligned with the Agency's work in surveillance, behavioural studies, laboratory quality assurance and strain surveillance and key population-specific status reports – are designed to work together to achieve Federal Initiative results in the area of improved access to more effective HIV/AIDS prevention, diagnosis, care, treatment and support for populations most affected by HIV/AIDS in Canada.

PHAC facts...

A process evaluation to assess HIV/AIDS program relevance is underway and will be finalized in the fall 2008. A comprehensive evaluation is planned for 2009-10.

Research

The Agency's laboratories, which are important for surveillance and for responding to health emergencies such as SARS or pandemic influenza, conduct scientific research and development in a wide range of areas related to viral, bacterial and prion infectious agents. They identify novel agents (e.g., new strains of influenza virus) as they arise, using a variety of approaches including genomics, proteomics (the study of the structure and function of proteins) and bioinformatics. They develop and apply these modern public health technologies to diagnostics, vaccines, and molecular epidemiology.

During 2007-2008, the Agency continued to develop unique capabilities as a national resource, with a focus on infectious disease prevention and control, the application of biotechnologies and genomics to population health, and mitigation of human illnesses arising from the interface between humans, animals, and the environment. Agency research supported public health officials and decision-makers in preventing and controlling disease in Canada.

2. Maintain and Enhance Quality of Life; and Minimize Complications and Premature Deaths in Persons with Disease

Steps taken during 2007-08 to maintain and enhance quality of life and to minimize complications and premature deaths in those with disease included the previously discussed initiatives in HIV/AIDS, plus the following disease-specific initiatives:

Cancer

In collaboration with the National Cancer Institute of Canada, the Canadian Cancer Society, and Statistics Canada, and under the guidance of the Canadian Cancer Statistics Steering Committee, the Agency provided the analysis and statistical support for the production of the *2008 Canadian Cancer Statistics* contributing in particular to the special chapter on childhood cancer, which was the theme for that year. This annual publication was widely distributed, read and referred to by health care professionals, researchers and policy makers working in the cancer field across Canada.

Diabetes

The Agency's collaboration with provinces and territories to update and enhance the National Diabetes Surveillance System (NDSS) reached key milestones in 2007-08. In March 2008, the first annual *Highlights from the National Diabetes Surveillance System* was released detailing ongoing, systematic and validated Canadian analysis for basic prevalence and other diabetes information. This report included two special Aboriginal projects conducted with the Québec James Bay Cree and the British Columbia First Nations populations. Discussions with National Aboriginal Organizations, researchers, and provinces and territories took place to determine how the NDSS is being used and how it could be used to support Aboriginal public health surveillance. Contribution agreements were put in place with three provincial Métis organizations to link their registries to the NDSS.

Building on the success of the NDSS in tracking diabetes prevalence in Canada in a cost-effective manner, the foundation was laid in 2007-08 for the scope to be expanded to become the National Chronic Disease Surveillance System.

Cardiovascular Disease (CVD)

Agency analysis of the data from the 2005 Canadian Community Health Survey conducted by Statistics Canada has revealed some startling facts. Nine in ten adult Canadians have at least one risk factor for cardiovascular disease and one in three have three or more risk factors (i.e., smoking, inadequate consumption of fruits and vegetables, high blood pressure, diabetes, overweight or obesity, high stress, and physical inactivity). To help address these issues, the Agency funded the development of a Canadian Heart Health Strategy and Action Plan, anticipated to be submitted to the federal Minister of Health in the fall of 2008. In the interim, the Agency continued its collaboration with the Canadian Hypertension Education Program, Blood Pressure Canada and the Canadian Hypertension Society to reduce high blood pressure prevalence and incidence in Canada.

PHAC facts...

Agency's support and collaboration with the Canadian Hypertension Education Program enabled real improvements in the management of high blood pressure in Canada. Two CVD implementation reviews carried out in 2005-06 and 2006-07 found efficient coordination and governance structures. As well, based on data from a 2007 independent survey, Canada is a world leader in high blood pressure treatment and control.

3. Decreased Personal, Social and Economic Burden of Disease for Individuals and Society

The steps taken above to minimize disease prevalence and the steps taken to reduce the impact of the disease the persons and families affected will assist in decreasing the personal, social and economic burden of disease for individuals and society. The Agency also continued to develop risk analysis and modeling methods that support policy and regulatory decision making processes, to support reducing the burden of disease in Canada and internationally.

PHAC facts...

The burden of preventable death and disease has been growing in Canada and internationally, reducing quality of life, increasing wait times for care, and challenging the sustainability of the health system. Agency analysis of Statistics Canada's Mortality Database and the 2005 Canadian Community Health Survey has discovered that chronic diseases cause four out of five deaths in Canada Two Canadians out of five aged 12 and over have at least one chronic disease. As these diseases are more prevalent in older people, the burden is growing as Canada's population is aging. Many of these chronic diseases have one or more common risk factors (e.g., smoking, inadequate consumption of fruits and vegetables, high blood pressure, diabetes, obesity, high stress, and physical inactivity).

4. Strengthened Response to Managing Diseases in Canada

The Agency fostered new partnerships and networks; coordinated networks of scientific experts, public health officials, advisory committees and working groups; proposed prevention and control strategies through sound policy analysis and public health advice; and targeted risk analysis and research to investigate diseases of provincial and/or national importance. These steps as well as others taken in the program activity strengthened the response to managing diseases in Canada.

Support from the other Program Activities

Initiatives undertaken in the Health Promotion program activity also support the achievement of minimized disease prevalence and decreased burden of disease. The same two expected results are supported by work done under the Emergency Preparedness and Response program activity, which funds the provision of quarantine services to safeguard the health of Canadians against communicable diseases that could be carried into Canada from abroad.

The work done in the Strengthening Public Health Capacity Program Activity supports the achievement of all the Disease Prevention and Control expected results. Relevant initiatives included the negotiation of information sharing agreements with the provinces and territories which are vital for secure surveillance; development and publication of a Surveillance Strategic Plan, and providing surveillance tools; training public health professionals in identifying and properly responding to infectious disease outbreaks, and providing tools such as the geographic information systems program; developing methods to better estimate the economic burden of illness in Canada, and publishing reports with such estimates; and supporting the National Collaborating Centres whose knowledge development and exchange work provides important information that the Agency makes available to stakeholders.

Exceptions

All Disease Prevention and Control Program Activity work planned in the RPP for the fiscal year 2007-08 was successfully achieved with the exception of:

- The publication of the sixth report on heart disease and stroke in Canada was delayed until 2008-09.

- Work began to revise the on-line data management and entry system for the winter 2007 national childhood surveillance study of cancer. However, due to short delays, the revised system did not come into operation in 2007-08.

- While the Agency continued funding the Canadian Breast Cancer Initiative, planned funding was excluded for care and treatment which are now under the mandate of the Canadian Partnership Against Cancer Corporation.

- The Canadian Immunization Committee, co-chaired and supported by the Agency, developed scientific and programmatic recommendations on Human Papillomavirus (HPV) to inform provinces/territories of options for immunization program planning. This work involved collaboration between the Canadian Immunization Committee and National Advisory Committee on Immunization Working Group. With Agency leadership and support, the Canadian Immunization Committee also developed draft scientific and programmatic recommendations on meningococcal vaccine programs. At the end of 2007-08, these recommendations were pending final review and approval.

- The Agency completed the planning and field work phase of the formative evaluation of the Federal Initiative to Address HIV/AIDS in Canada. The Agency reviewed internal documents and conducted key interviews to assess relevance, progress, and issues related to the delivery and design of the Federal Initiative during the period 2003-04 to 2006-07. It is expected that the evaluation report will be finalized in 2008.

- Although a national registry for bone marrow transplant recipients was not established in 2007-08 (awaiting access to the National Microbiology Laboratory infrastructure), the Agency made notable progress on several contributing activities. For example, the Agency worked on creating the Canadian Bone Marrow Transplantation Surveillance System to assess the incidence and risk of transmission of bloodborne pathogens like HBV, HCV and HIV in bone marrow recipients.

- The Agency undertook the implementation of a national cell, tissue, organ and assisted human reproduction surveillance system. At the end of 2007-08, the system remained in its pilot phase because some data were not yet available from the provinces/territories.

- The Agency did not start clinical trials on a H5N1 mock pandemic vaccine produced in Canada. A contract was in place with GlaxoSmithKline Inc. (GSK) to undertake the clinical trials, but due to changes in company ownership, GSK did not solicit federal funding for the clinical trials in 2007-08. However, GSK proposals for clinical trials were received in 2008-09.

Benefits to Canadians

The Agency made progress toward its expected results of decreased proportion of Canadians who develop or acquire disease; maintained and enhanced quality of life; fewer complications and premature deaths in those with disease; decreased personal, social and economic burden of disease for individuals and society; and strengthened response to managing diseases in Canada through public health surveillance; immunization and pandemic preparedness; activities to prevent and control of infectious diseases; and provision of unique research and testing capabilities. For more information on this program activity, please visit: (http://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.phphttp://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.php)

Program Activity – Emergency Preparedness and Response

Financial Resources ($ millions)

Planned Spending	Total Authorities	Actual Spending
115.9	137.8*	121.3**

* The $21.9 million net increase between planned spending and authorities is due to: (a) increase of $13.1 million resulting from realignment of resources between program activities to cover increased operating requirements; b) increase of $8.5 million for transfers from Treasury Board votes for the operating budget carry-forward from 2006-07 ($7.7 million), and to cover other operating requirements such as collective agreements ($0.2 million) and uncontrollable salary costs ($0.6 million); (c) increase of $0.2 million for Employee Benefit Plan costs; and (d) increase of $0.1 million for items in Supplementary Estimates (A) not included in Planned Spending.

** Actual Spending in operating expenditures was $16.5 million lower than Authorities due to: (a) the deferment of funding for National Antiviral Stockpile to subsequent fiscal years ($12.5 million); and (b) capacity and technical constraints which impeded the full utilization of approved resources ($4.0 million).

Human Resources (Full-Time Equivalents)

Planned	Actual	Difference
367	353	14*

*The difference of 14 Full-Time Equivalents is due to: (a) delays in the staffing process; (b) difficulty in finding qualified personnel because of low labour market availability for positions requiring unique public health specialization; and (c) constraints due to shortage of accommodation space.

The Agency provides a national focal point for anticipating, preparing for, responding to and facilitating recovery from threats to public health, and/or the public health complications of natural disasters or human caused emergencies.

Performance Analysis

The Agency's National Emergency Stockpile System (NESS) has the ability to ship health supplies anywhere in Canada with 24-hours notice, 24 hours / 7 days a week. In 2007-08, those NESS stockpile contents that were approaching their expiry dates were updated. As well, there was an increase in the number of doses and in the number of drugs kept in the stockpile, including antiviral drugs such as those for Pandemic Influenza. The NESS was successfully activated for two emergencies – flooding in Saskatchewan and Alberta; and in conjunction with the Canadian Food Inspection Agency to protect persons culling chickens with avian flu in Saskatchewan.
NESS also supported the Agency's work towards meeting the provisions of the WHO's International Health Regulations (IHR) and the Canada–US–Mexico Safety and Prosperity Partnership Agreement.

In 2007-08, the Agency put in place Canada's first Health Emergency Response Team (HERT) in Eastern Ontario/Western Quebec. With more than 200 people in rapid response, mission support and medical response teams, this HERT was recruited, trained and exercised to readiness standards where they would make a measurable contribution to public health and safety in a disaster. All aspects of a HERT Unit deployment involving logistics, equipment and supplies, were validated as a planning function and in a field environment. While the unit is ready for deployment, there has been no request from provinces and territories for federal assistance.

PHAC facts...

In 2007-08, the Agency successfully conducted such emergency exercises as:

- *CADEOUS MAJOR 07, the largest, most complex exercise of its kind in Canadien history (which built on lessons learned from smaller exercises held in June and in October 2006);*
- *BI-EX WEST, a series of two tabletop exercises and one field trial designed to enhance the capability of organizations to respond to biological terrorist events; and*
- *JUDICIOUS ALERT to test the notification process and issues management to be used during the first few hours following the identification of an influenza pandemic index case in Canada.*

Memoranda of Understanding (MOUs) were developed and implemented between the Agency and its international partners (e.g., WHO, the US Centers for Disease Control, and European partners) who were connected to the Agency's Health Portfolio Emergency Operations Centre. The MOUs allowed units within the Agency to build relations with respective international partners. Operational procedures and processes were put in place during February 2008, including regular tests conducted with the international partners. Communication testing between Canada and the US were expanded to include Mexico.

The Agency provided funding and secretariat support for expert groups on emergency preparedness and response including the Pandemic Preparedness Health Operations Coordination Expert Working Group, the Public Health Network Council, the Council of Chief Medical Officers of Health, the Council of Health Emergency Management Directors (provincial and territorial disaster, health, and emergency health personnel) and the Council of Emergency Social Services Directors.

The Agency began significant work towards the implementation of the WHO's IHR. In 2007-08 the basic structure was put in place for the Agency's Emergency Operations Centre system to have capacity to operate around the clock – required for achieving IHR compliance by 2012.

Agency expertise in laboratory biosafety is recognized worldwide and as one of five designated WHO Biosafety Collaborating Centres, the Agency provided training to over 18 African countries in a week-long biosafety outreach workshop. The Agency was mandated to implement the Human Pathogens Importation Regulations and issued approximately 2000 import permits to allow human pathogens to enter Canada into approved laboratories. In 2007-08 the Agency published and continued to maintain the Laboratory Biosafety Guidelines to ensure that best practices are used in Canadian labs, thus protecting the health of workers, the community and the environment. In addition, the Agency monitored for any accidental release of biological materials from certified facilities.

The Agency provided $25 million funding to InterVac – the International Vaccine Centre to be located in Saskatchewan which will focus on vaccine development for both animal and human pathogens. The Agency also provided a detailed, technical microbiological and engineering biocontainment review as the preliminary step to the facilities inspection and certification to ensure compliance to the national biosafety guidelines.

The Agency operated a nationwide quarantine service staffed by nurses and physicians based at the six airports that have 94% of international travellers: Vancouver, Calgary, Toronto, Ottawa, Montreal and Halifax. Three additional quarantine officers were hired during 2007-08 to augment coverage for the Vancouver, Montreal and Halifax marine ports.

The Agency strengthened its regional presence across the country by expanding the role of its Regional Offices and adding core public health functions such as emergency preparedness and response, public health knowledge development and exchange, public health policy, planning and intergovernmental relations, surveillance and coordination of the Canadian Public Health Service Program.

Support from the Agency's other Program Activities

The achievement of the Emergency Preparedness and Response expected result was assisted by the work done for the strengthening public health capacity program activity (e.g. expanding and training the public health workforce, negotiating agreements to share information and to provide mutual aid in the event of a public health emergency, and providing information systems to monitor public health incidents and quickly identify outbreaks).

Work done in the Agency's Disease Prevention and Control Program Activity also helps to ensure that Canada is one of the countries best prepared to respond to the public health risks posed by natural and human-caused disasters. For example, laboratories are staffed with scientific and technical personnel capable of identifying outbreak strains and test pathogen infectiousness – and how a spread can be stopped – is an important element of preparedness for a future outbreak.

All Emergency Preparedness and Response Program Activity work planned in the RPP for the fiscal year 2007-08 was achieved.

Benefits to Canadians

The Agency made progress toward its expected result of "Canada is one of the countries best prepared to respond to the public health risk posed by natural and human-caused disasters, such as infectious disease outbreaks, hurricanes, floods, earthquakes and criminal or terrorist acts such as explosions and the release of toxins" by conducting its planning and testing of exercises, and negotiating and implementing international commitments. For more information on this program activity, please visit: (http://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.php).

Program Activity – Strengthen Public Health Capacity

Financial Resources ($ millions)

Planned Spending	Total Authorities	Actual Spending
55.6	55.8*	53.0**

*The $0.2 million net increase between planned spending and authorities is due to: (a) increase of $1.0 million for transfers from Treasury Board votes for the operating budget carry-forward from 2006-07 ($0.2 million), and to cover collective agreements ($0.2 million) and uncontrollable salary costs ($0.6 million); (b) increase of $0.1 million for items in Supplementary Estimates (A) not included in Planned Spending; (c) decrease of $0.3 million resulting from realignment of resources between program activities; and (d) decrease of $0.6 million due to reduction in Employee Benefit Plan costs.

** Actual Spending was $2.8 million lower than Authorities due to capacity and technical restraints which impeded the full utilization of approved resources ($2.3 million in operating expenditures) and due to delays in the approval and solicitation process ($0.5 million in transfer payments).

Human Resources (Full-Time Equivalents)

Planned	Actual	Difference
311	263	48*

*The difference of 48 Full-Time Equivalents is due to: (a) delays in the staffing process; (b) difficulty in finding qualified personnel because of low labour market availability for positions requiring unique public health specialization; and (c) constraints due to shortage of accommodation space.

Working with national and international partners, the Agency developed tools, applications, practices, programs, training and understandings that supported, improved and expanded the capabilities of public health practitioners across Canada.

Performance Analysis

The public health human resources were strengthened by providing training opportunities in public health; developing and delivering on-line modules for distance learning in public health; identifying the core competencies for public health practice; providing scholarships and bursaries for research work and career advancement in public health; deploying human resources in support of surveillance and disease control as part of surge capacity in jurisdictions; negotiating with Agency partners for these deployments across Canada; and providing essential support to the Public Health Human Resource Task Group and its working groups.

PHAC facts...

The Agency has Canada's foremost field epidemiology training program which has produced some of the country's leading medical and public health professionals. This program has contributed to the investigation of outbreaks and environmental health risks across Canada and around the world.

Knowledge and information systems were strengthened by promoting innovative Agency tools and solutions to its stakeholders. This includes the Public Health Map Generator – an online tool that allows public health practitioners to prepare maps of health event data such as that of an outbreak, and the integrated Public Health Information System – a tool provided to provinces and territories to support public health case management and better surveillance of outbreaks. The Agency provided support to the National Collaborating Centres for knowledge translation activities; enhanced the Agency data infrastructure including acquisition, cleaning, value-added restructuring and analysis, and provided data access to professionals across the Agency. The Agency also provided essential support to the Surveillance and Information Expert Group of the Public Health Network; worked with national partners to prepare a Memorandum of Agreement on information sharing during public health emergencies; and established a surveillance strategic plan. As well, the Chief Public Health Officer's Annual Report on the State of Public Health in Canada was prepared in 2007-08 and published in 2008-09.

The public health law and ethics component was strengthened by concentrating on conducting research and analysis on law-based interventions, practices and tools; providing these analyses to practitioners to increase their knowledge base and strengthen their competencies in applying law and ethics to public health practice; and providing consultation and discussion opportunities to share best practices.

Exceptions

All Strengthen Public Health Capacity Program Activity work planned in the RPP for the fiscal year 2007-08 was successfully achieved with the exception of:

- Finalizing a comprehensive professional development plan for all Agency staff. Although the Agency worked to finalize a comprehensive professional development plan for its staff in 2007-08, it was determined that more time will be required to gather staff learning needs in some key competency areas such as surveillance and chronic diseases, which are two of the key functions that the Agency performs. The plan will be tabled with Senior Management of the Agency in 2008-09.

- Launching three new modules in its Skills Enhancement for the Public Health Program. The Agency piloted three modules and launched two others -"Basic Biostatistics" and "Communicating Data Effectively".

- Due to shifting priorities, the Agency did not collaborate with the WHO in developing public health legislative strategies and tools intended for tabling at the World Health Assembly in 2008. Priorities were shifted to reflect the immediate need to address implementation of the International Health Regulations, a legally-binding agreement administered by the WHO to help countries to identify, contain and control health risks.

Benefits to Canadians

Overall, the Agency's initiatives increased public health capacity in Canada and helped the Agency achieve progress in preparing the country for health emergencies, and in providing national leadership for disease prevention and control. For more information on this program activity, please visit: (http://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.php).

Overall Lessons Learned

Having been created in September 2004, the Agency is at an early stage of development and performance. However, there have already been some overarching lessons learned.

Partnerships and Stakeholders

Given that the Agency's expected results and strategic outcome are realized over the long term, it is important to make progress on those areas where the Agency's federal role is clearly defined. Since the public health system involves many partners and stakeholders, effective consultation with government and non-government stakeholders is a pre-requisite for successful policy implementation which requires openness, thoughtful negotiations, and program delivery. This lesson was also learned as part of the Agency's first phase of an initiative on intersectoral action (IA) for health which examined approaches at the global, sub-regional, national, sub-national, and community levels in more than 15 countries and found that:

- The broader context for decision-making (political, economic and socio-cultural) affects how issues are framed and the choice of approaches (including IA), mechanisms and tools to address the problem.
- IA is a strategy that can address a wide range of health problems.
- IA is both dynamic and resource-intensive in terms of people, money and time.
- As the number of partners and interests increases, logistical challenges make it more difficult to initiate and sustain IA. More documented success stories of IA appear at the community level than at the national and global levels, and many sources acknowledge the problem of increasing complexity at higher levels of governance

Other initiatives have shown that partnership-enabled community-based organizations to extend their reach and undertake programs much more effectively than on their own. Collective action undertaken through partnership development and collaboration with others is more likely to achieve success. This is particularly valuable in the areas of promotion and advertising since using partners enhances program participation rates. Similarly, finding and supporting "champions" – people/organizations who are committed to the work – is essential to the development and implementation of initiatives. The importance of building a shared vision is another critical success factor in ensuring the initial and ongoing commitment of partners. The need for continuous communication and associated mechanisms is fundamentally important for policy changes affecting many stakeholders.

Surveillance

Over the years, the Office of the Auditor General of Canada (OAG) has assessed the surveillance of infectious diseases (including when such responsibilities belonged to Health Canada prior to the Agency's creation). In the May 2008 report, the OAG acknowledged that the Agency has a strong laboratory capacity that provides a base for detecting and describing new diseases. However, more work needs to be done with partners to establish an action plan for implementing the MOU on the sharing of information during a public health emergency. The Agency has committed to take action to address these and other concerns. For example, while the MOU has not been officially approved, the Agency is already working to

implement the MOU, as it is on the meeting agenda of the F/P/T Ministers of Health in September 2008. In addition, the Agency made progress by developing a surveillance strategy and establishing the Surveillance Integration Team to improve and better integrate surveillance activities across the Agency. (http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_200805_05_e_30701.html)

Public Service Renewal

As a new organization, there has been a high risk in the Agency's ability to attract and retain competent and skilled people, and in developing internal capacity to address skill requirements needed to deliver on its commitments. In an effort to address these issues, the Agency took a step forward towards developing an Integrated Business and Human Resource Plan to strengthen succession planning, to identify gaps in the workforce, and to put in place the human resource strategies to close those gaps and meet business needs. The Agency will improve integration based on lessons learned from the previous planning exercise in support of Public Service Renewal.

PHAC facts...

Public Service Renewal "is about making sure that the federal public service preserves and strengthens its capacity to contribute to Canada's successes through the delivery of excellent public services and policy advice".

Revising and improving plans is an indication of sound management practices. Plans are expected to change in response to lessons learned from past performance as well as new circumstances. Thus the Agency intends to continue to validate its 2007-12 Strategic Plan on an annual basis.

Management, Results and Resources Structure

Developing a sustainable and useful Management, Results and Resources Structure (MRRS) is a major undertaking that requires dedicated time, effort and leadership from all management levels, planning and performance advisors, functional specialists (e.g., finance, human resources, science), and others. As the Agency looks to redevelop its MRRS, it will apply lessons from previous exercises to identify what works well, what does not, and what is essential to fulfill the MRRS policy objective.

Audit and Evaluation

The Agency has made significant progress in developing its internal audit capacity with the establishment of an Internal Audit Committee including a panel of 3 distinguished external, independent members. Invaluable audit lessons learned, oversight and guidance are the cornerstone elements for the way ahead.

The Agency requires additional evaluation information to assess the effectiveness of its program activities. A five-year Evaluation Plan will be developed to inform senior management of the scope of the Agency's evaluation commitments to the Treasury Board Secretariat (TBS). This Plan will help to ensure compliance with the requirements of the *Federal Accountability Act* and to evaluate 100% of grant and contribution programs. A copy of the approved Plan will be forwarded to TBS and will be available on the Agency website.

In preparing for the implementation of the upcoming TBS Evaluation Policy, the Agency will be reviewing its evaluation processes and products. Examples of activities include reviewing the Terms of Reference for the Evaluation Advisory Committee; revising the format and content of the Agency Evaluation Plan; and developing an Agency-specific Evaluation Policy.

Supplementary Information

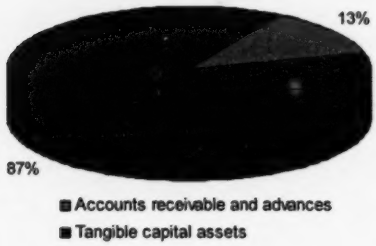
Section III

Financial Highlights

The financial highlights presented are intended to serve as a general overview of the Agency's financial position and operations. Financial statements can be found on the Agency's website at:
http://www.phac-aspc.gc.ca/dpr-rmr/2007-2008/index-eng.php.

FINANCIAL HIGHLIGHTS			
(in dollars)	% Change	2008	2007
Condensed Statement of Financial Position At March 31			
ASSETS	6%	76,150,383	71,585,543
LIABILITIES	36%	181,365,470	133,743,601
EQUITY OF CANADA	69%	(105,215,087)	(62,158,058)
TOTAL	6%	76,150,383	71,585,543
Condensed Statement of Operations At March 31			
EXPENSES	13%	607,098,260	536,098,033
REVENUES	54%	525,261	341,495
NET COST OF OPERATIONS	13%	606,572,999	535,756,538

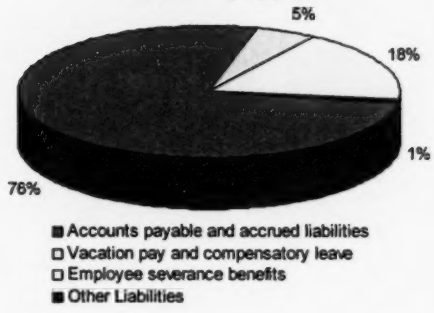
Assets by Type

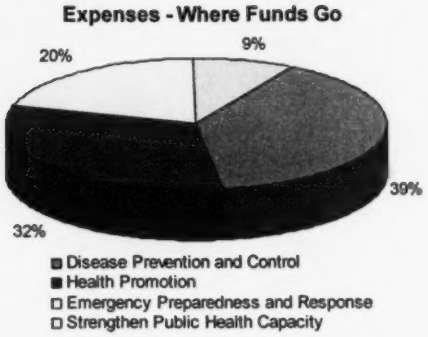


Total assets were $76.2 million at the end of 2007-08; an increase of $4.6 million (6%) over the previous year's total assets of $71.6 million. Tangible capital assets represented $66.6 million (87%) while accounts receivable and advances represented $9.5 million (13%) of total assets.

Total liabilities were $181.4 million at the end of 2007-08, an increase of $47.6 million (36%) over the previous year's total liabilities of $133.7 million. Accounts payable represents the largest portion of liabilities at $138.5 million or 76% of total liabilities.

Liabilities by Type





Total expenses for the Agency were $607.1 million in 2007-08. The Agency spent $239.7 million (39%) on disease prevention and control, $192.2 million (32%) on health promotion, $122.6 million (20%) on emergency preparedness and response and $52.5 million (9%) on strengthening public health capacity. As detailed in Sections I and II, expected results were partially met for disease prevention and control and successfully met for health promotion, emergency preparedness and response, and strengthening public health capacity.

Table 1: Comparison of Planned to Actual Spending (including Full-Time Equivalents)

			2007–08			
($ millions)	2005–06 Actual	2006–07 Actual	Main Estimates	Planned Spending	Total Authorities	Actual
Health Promotion	199.2	202.7	186.4	186.5	200.2	192.1
Disease Prevention and Control	211.5	242.4	300.5	311.8	290.3	240.5
Emergency Preparedness and Response	41.1	31.5	115.8	115.9	137.8	121.3
Strengthen Public Health Capacity	25.4	34.2	55.6	55.6	55.8	53.0
Total	**477.2**	**510.8**	**658.3**	**669.8**	**684.1**	**606.9**
Less: Non-respendable revenue	0.2	0.3	0.0	0.0	0.0	0.5
Plus: Cost of services received without charge	17.6	21.0	N/A	22.7	22.7	17.7
Total Spending	**494.6**	**531.5**	**658.3**	**692.5**	**706.8**	**624.1**
Full-Time Equivalents*	1801	2050	2376	2376	2410	2165

* Full-Time Equivalents (FTE) are a measure of human resource consumption based on average levels of employment.

Table 2: Voted and Statutory Items

($ millions)

Vote or Statutory Item	Truncated Vote or Statutory Wording	2007–08 Main Estimates	Planned Spending	Total Authorities	Total Actual
35	Operating expenditures	438.4	446.1	457.4	393.3
40	Grants and contributions	189.3	192.5	201.8	188.7
(S)	Contributions to employee benefit plans	30.6	31.2	24.9	24.9
	Total	**658.3**	**669.8***	**684.1****	**606.9*****

* The $11.5 million increase from Main Estimates to Planned Spending is mainly due to increased funding for renewed public health response to address hepatitis C.

** Please refer to Section I, Table entitled "Financial Resources" for explanations of the $14.3 million increase from Planned Spending to Total Authorities.

*** Please refer to Section I, Table entitled "Financial Resources" for explanations of the $77.2 million decrease from Total Authorities to Total Actual.

The following tables are available online:

Table 3: Sources of Respendable and Non-Respendable Revenue

For supplementary information on the Agency's sources of Respendable and Non-respendable Revenue, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 4–A: User Fees Act

For supplementary information on the Agency's User Fees, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 4–B: Service Standards for External Fees

For supplementary information on the Agency's Service Standards for External Fees, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 5: Details on Project Spending

For supplementary information on the Agency's Details on Project Spending, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 6: Details on Transfer Payment Programs

For supplementary information on the Agency's Details on Transfer Payment Programs, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 7: Foundations (Conditional Grants)

The Agency provided a one-time conditional grant of $100 million in 2004-05 for the Public Health Surveillance aspects of Canada Health Infoway's electronic health information work. The Agency's progress report is combined with Health Canada's report on other aspects of Infoway's work, and can be found in Health Canada's Departmental Performance Report. For further information, please visit the

Health Canada supplementary information at: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 8: Horizontal Initiatives

For supplementary information on the Agency's Horizontal Initiatives, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 9: Sustainable Development Strategy

For supplementary information on the Agency's Sustainable Development Strategy, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 10: Response to Parliamentary Committees and External Audits

For supplementary information on the Agency's Response to Parliamentary Committees and External Audits, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 11: Internal Audits and Evaluations

For supplementary information on the Agency's Internal Audits and Evaluations, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp

Table 12: Travel Policies

For supplementary information on the Agency's Travel Policies, please visit: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp